DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155005	B. WIN			08/23/2	011
NAME OF F	AN OLUMBER OR GUIRRU HER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1345 N	MADISON AVE		
MANOR	CARE HEALTH SER	RVICES		ANDER	RSON, IN46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORREC	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
F0000							
	This visit was for the Investigation of Complaint IN00095160. Complaint IN00095160- Substantiated, federal/state deficiencies related to the		F0	000	September 9, 2011 Long Te	rm	
					Care Division, 4 th Floor2 North Meridian StreetIndianapolis, IN		
					46204 RE: ManorCare Hea	lth	
					Services of Anderson 1345 Madison Ave. Anderson, IN	VIN.	
					46011 Dear Kim		
		ted at F282, F333, and			Rhoades: Enclosed is our Pl	an of	
	F371.				Correction and credible alleg of compliance for our compla		
	Survey date: August 23, 2011				survey completed on Septen		
					22, 2011. If you should have	e any	
	Facility number:	000005			other questions or need addi information, please contact n		
	Provider number	: 155005			the above address or phone	ic at	
	AIM number:	100270840			numbers. You may also cont	act	
	Surveyor: Jeri Cu	urtis, RN			421admin@hcr-manorcare.c Sincerely, Nicole Fields, HFAAdministrator	om.	
	Census bed type:				TH AAdministrator		
		21					
	SNF/NF: 14						
	Total" 162	2					
	Census payor typ	oe:					
	Medicare:	21					
		121					
	Other:	20					
		162					
	101.	102					
	Sample: 4						
	These deficiencie	es also reflect state					
	findings cited in accordance with 410 IAC						
	16.2.						
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 000005

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/23/2011
	PROVIDER OR SUPPLIER		1345 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011	00/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	Quality review of 2011 by Bev Fau The services provifacility must be proin accordance with plan of care. Based on observation interview, the fact physicians' order administration of control blood sugnarcotic and anal management. The Band C) of 4 rest of 4, reviewed for Findings include During the 8/23/entrance tour, Lie #1 and #2, were medications on the 12/23/11, and indipassing the 8:00 #1 indicated she the dining room adelayed the medications on according to the service of th	ompleted on August 29, alkner, RN Ided or arranged by the byided by qualified persons a each resident's written ation, record review, and belity failed to ensure as were followed for the fan anti-glycemic to gar levels, and for a gesic patch for pain is affected 2 (Residents sidents among the sample or physician orders. 11, 9:20-11:30 A.M., censed Practical Nurses	F0282	What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice; Diabetic Managen review completed for resider including medications and la Results reviewed by Primary Physician. Resident's stock of medications are available for administration per the physician order. Pain management recompleted for resident C. Reserviewed by Primary Care Physician. One on one eduction completed with LPN # 1 and on medication pass guideline include completion within 60 minutes before or after the ordered time. How other residents having the potent to be affected by the same deficient practice will be identified and what correcting actions will be taken; All residents receiving medication by the same deficient practice.	vill 09/22/2011 en
	indicated she had	-		•	ce. ted

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155005	B. WIN			08/23/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	MADISON AVE	
MANOR	CARE HEALTH SEF	RVICES		1	SON, IN46011	
				L		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	residents.				Guidelines. What measures be put into place or what	<u>; wiii</u>
		d the facility policy was			systemic changes will be m	ada
	for medications	to be administered within			to ensure that the same	<u>ade</u>
	1 hour on either	side of the scheduled			deficient practice does not	
	hour. LPN #1 in	dicated she was at the end			recur; A review of the staffing	· I
	of the pass, with	3 more residents who			pattern and workload was	
	still required 8:00 A.M. medications.				completed and presented to	
	1				QA&A Committee for review	and
	Observation of the	he administration of the			approval of changes.	
					Adjustments to the Family Tr and Intermediate Unit include	
		cations to Resident (B),			additional medication cart an	
	l -	observed at 10:35 A.M.,			nurse to facilitate completion	I
		dications included the			the medication pass within th	
	1 -	Glucophage 1500			guidelines. Licensed staff w	ill be
	milligrams (mgs) to be given every 8:00			educated on the Medication	
	A.M., daily, and	Glimepiride 4 mgs to be			Administration Guidelines to	
	given twice daily	ý.			include completion within the minutes before and after	: 60
	, ,	was not stocked in the			scheduled medication times	and
	1	f Resident (B). LPN #1			physician notification if unable	
	_	cation and indicated she			complete medication pass.	
					Nurses will also be educated	
		e Glucophage and			regarding utilization of the	
	administer it late	er.			Emergency Drug Kit as a back	
					if medications are not in stoc	k for
	LPN #2 was obs				a specific resident to ensure medications are delivered pe	or the
	medications on a	nother hall on Family			physician's order. How the	1 410
	Tree at 10:58 A.	M. Observation of the			corrective action(s) will be	
	8:00 A.M., medi	cation pass to Resident			monitored to ensure the	
	(C) was observed	d at 10:58 A.M., 8/23/11.			deficient practice will not	
	` ′	included Morphine			recur; i.e., what quality	
		d Release 30 mg,			assurance program will be	<u>put</u>
		0 A.M., and 8:00 P.M.,			into place;	
	and Ben Gay pain relief patch, scheduled				Medication Administration observations will be conducted	on all
		and off at 8:00 P.M.			shifts for a total of 12 observation	
					week times four weeks with fin	
		d Resident (C) needed the			presented weekly to the QA & A	- I
	medications befo	ore his morning care. LPN			r seems with to me green	

000005

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155005	B. WING			08/23/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	Ł		1345 N	MADISON AVE		
	CARE HEALTH SEF	RVICES			SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		ident (C) had refused			committee for review. Observat will continue for a minimum of		
	1	til the medications were			months. QA & A committee wi		
	received.				review findings and determine i		
					for further monitoring and educ		
	The record of Re	esident (B) was reviewed			per the QA & A process.		
	at 11:50 A.M., 8	/23/11, and indicated					
	diagnoses includ	ing Diabetes Mellitus II.					
	On 1/28/10, the 1	physician had ordered					
	Glimepiride 4 m						
	On 8/21/11, the i	ohysician had ordered					
		0 mg every morning (8:00					
	1 .	mg every 4:00 P.M.					
	1	olan concern of an					
		n need for monitoring					
	1	dependent diabetes and					
		cose readings, had been					
	1	goal target date of					
		goar target date of					
	10/20/11.	1 1 1 1					
		cluded administering					
	medications as p	er MD (physician) orders.					
	The record of Re	esident (C) was reviewed					
		A.M. Diagnoses					
	included chronic	C					
		right below the knee					
	· · · · · · · · · · · · · · · · · · ·	A) and a non-healing					
	surgical wound.	i, and a non nouning					
	1	ders included 6/14/11,					
		trength patch to be					
	1 -	U 1					
	1	to right hip, on 12					
	`) and off 12 hours (8:00					
		11, Morphine sulfate ER					
	,	e) twice daily (8:00 A.M.,					
	and 8:00 P.M.).						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			<u> </u>		INSTRUCTION 00	(X3) DATE S COMPL	
		155005	A. BUI B. WIN	LDING		08/23/2	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1345 N	MADISON AVE		
	CARE HEALTH SER			ANDERSON, IN46011			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		of care, had been	+	IAU			DATE
	•	goal target date through					
	· ` `	ing a pain risk evidenced					
	by complaint of						
		ventions included					
		e pain medication as per					
	_	ote effectiveness.					
		olan concern was resident					
	•	ntom pain related to					
		29/11, target goal of					
	· · · · · · · · · · · · · · · · · · ·	t affect participation in					
	daily care.	· ·					
	, ,						
	During an 8/23/1	1, 3:00 P.M., interview,					
	_	Jursing (DoN) indicated					
	facility protocols	required the plan of care					
	be followed for e	each resident.					
	The DoN provid	led the facility's 3/10					
	"Medication Adn	ministration: Medication					
	Pass Policy" on 8						
		ed medications were to be					
		th frequency prescribed					
		-within 60 minutes before					
	or after prescribe	ed dosing time.					
	This follows to	-1-4 4- Co1-1-4					
	_	relates to Complaint					
	IN00095160.						
	3.1-35(g)(2)						

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155005	B. WING			08/23/2	011
NAME OF F	PROVIDER OR SUPPLIER		D. 1121		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1345 N I	MADISON AVE		
MANOR	CARE HEALTH SER	RVICES		ANDER	SON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0333 SS=D	The facility must e free of any signific Based on observatinterview, the fact anti-glycemics to levels, and a narce for pain manager on the scheduled physicians for 2 tresidents in a same dication admit This deficient propotential for hyphand uncontrolled Findings include During the 8/23/entrance tour, Lie #1 and #2, were medications on the S/23/11, and indications in the S/23/11, and indications in the S/23/11, and indications of the series of	nsure that residents are ant medication errors. Action, record review, and cility failed to ensure to control blood sugar otic, and analgesic patch ment, were administered times ordered by the (Residents B and C) of 4 anple of 4 reviewed for mistration. Actice provided a coglycemia (Resident B) pain (Resident C).	F0	333	What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice; Diabetic Management review completed for resident including medications and late Results reviewed by Primary Physician. Resident's stock of medications reviewed to ensumedications are available for administration per the physician order. Pain management reviewed by Primary Care Physician. One on one educicompleted with LPN # 1 and on medication pass guideline include completion within 60 minutes before or after the ordered time. How other residents having the potent to be affected by the same deficient practice will be identified and what correcting actions will be taken; All residents receiving medication have the potential to be affected.	nent t B os. Care of ure ian's riew sults ation #2 s to	09/22/2011
		had to stop and monitor			by the same deficient practice	e.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155005 08/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1345 N MADISON AVE MANORCARE HEALTH SERVICES ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Licensed staff will be educated the dining room at breakfast which had on the Medication Administration delayed the medication pass. LPN #1 also Guidelines. What measures will indicated she had not worked the unit for be put into place or what some time and was not familiar with the systemic changes will be made residents. to ensure that the same deficient practice does not LPN #1 indicated the facility policy was recur; A review of the staffing for medications to be administered within pattern and workload was 1 hour on either side of the scheduled completed and presented to hour. LPN #1 indicated she was at the end QA&A Committee for review and of the pass, with 3 more residents who approval of changes. Adjustments to the Family Tree still required 8:00 A.M. medications. and Intermediate Unit include an additional medication cart and Observation of the administration of the nurse to facilitate completion of 8:00 A.M., medications to Resident (B), the medication pass within the guidelines. Licensed staff will be by LPN #1 was observed at 10:35 A.M., educated on the Medication 8/23/11. The medications included the Administration Guidelines to anti-glycemics, Glucophage 1500 include completion within the 60 milligrams (mgs) to be given every 8:00 minutes before and after scheduled medication times and A.M., daily, and Glimepiride 4 mgs to be physician notification if unable to given twice daily (8:00 A.M., and 8:00 complete medication pass. P.M.). Nurses will also be educated The Glucophage was not stocked in the regarding utilization of the Emergency Drug Kit as a back up unidosage box of Resident (B). LPN #1 if medications are not in stock for circled the medication and indicated she a specific resident to ensure would obtain the Glucophage and medications are delivered per the administer it later. physician's order. How the corrective action(s) will be monitored to ensure the LPN #2 was observed passing deficient practice will not medications on another hall on Family recur; i.e., what quality Tree at 10:58 A.M. Observation of the assurance program will be put 8:00 A.M., medication pass to Resident into place; Medication Administration (C) was observed at 10:58 A.M., 8/23/11. observations will be conducted on all The medications included Morphine shifts for a total of 12 observations a Sulfate Extended Release 30 mg,

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155005	B. WIN			08/23/2	011
		<u> </u>	P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			MADISON AVE		
	CARE HEALTH SE	RVICES		1	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG		1'	DATE
		0 A.M., and 8:00 P.M.,			week times four weeks with fit presented weekly to the QA &	•	
	1	in relief patch, scheduled			committee for review. Observa		
	on at 8:00 A.M., and off at 8:00 P.M.				will continue for a minimum o		
	LPN #2 indicate	d Resident (C) needed the			months. QA & A committee w		
	medications before his morning care. LPN #2 indicated Resident (C) had refused morning care until the medications were received.				review findings and determine	need	
					for further monitoring and edu	cation	
					per the QA & A process.		
	LPN Unit Mana	ger #1 was interviewed at					
	1	3/11, and indicated if a					
	1						
	nurse found herself out of compliance with administration times, which						
		time to time, the physician					
	1 ^ ^	party of the resident were					
	1 -						
		PN Unit Manager #1					
	1	y the medication hours					
	1	adjusted with the other					
	medication time						
		ger #1 indicated the					
		n the unit was 58, with 3					
	1	on duty on days for					
	medication adm	inistration. LPN Unit					
	Manager #1 indi	cated the halls were split					
	and each nurse h	nad 18-19 residents for					
	medication adm	inistration.					
	The record of R	esident (B) was reviewed					
	1	/23/11, and indicated					
	1	ling Diabetes Mellitus II.					
	1 -	physician had ordered					
		g, twice daily (8:00 A.M.,					
	and 8:00 P.M.).	15, twice daily (0.00 A.1vi.,					
	1	nhygigian had ardarad					
	$\int On \delta/21/11$, the	physician had ordered					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155005	B. WIN			08/23/20	011
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NAME OF I	PROVIDER OR SUPPLIEI	₹			MADISON AVE		
	CARE HEALTH SEI				RSON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	+	LSC IDENTIFYING INFORMATION)	+	IAG			DATE
	1 .	0 mg every morning (8:00					
	· '	mg every 4:00 P.M.					
	A 5/26/10, care plan concern of an						
	endocrine system need for monitoring						
	related to insulin dependent diabetes and						
		cose readings, had been					
		goal target date of					
	10/20/11.						
		cluded administering					
	medications as p	per MD (physician) orders.					
	The record of Resident (C) was reviewed						
	8/23/11, at 11:35	A.M. Diagnoses					
	included chronic	pain syndrome,					
	osteoarthritis, a	right below the knee					
	amputation (AK	A) and a non-healing					
	surgical wound.						
	The physician or	rders included 6/14/11,					
	Ben Gay Ultra S	trength patch to be					
	applied topically	to right hip, on 12					
	1	.) and off 12 hours (8:00					
	`	11, Morphine sulfate ER					
	(extended releas	*					
	`) A.M.,, and 8:00 P.M.)					
	1	n of care had been					
	1	goal target date through					
		ting a pain risk evidenced					
	by complaint of						
		rventions included					
		e pain indication as per					
	1	note effectiveness.					
		plan concern was resident					
	1	•					
		ntom pain related to					
	AKA, with a 10	/29/11, target goal of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155005		(X2) MU A. BUII		NSTRUCTION 00	COMPI	LETED	
		155005	B. WIN			08/23/2	011
	PROVIDER OR SUPPLIER			1345 N	DDRESS, CITY, STATE, ZIP CODE MADISON AVE		
MANOR	CARE HEALTH SER			ANDER	SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	analgesia will no daily care.	t affect participation in					
	On 8/23/11, the I (DoN) provided to Omnicare, hand-website, (omnivie /Web/DrugInfo/I -6061, and 6309) The DoN indicate Omnicare website dosage, potential contraindications interactions. The DoN indicate were also allowed supplemental drug factor inform (Glimepiride), a reviewed. The weindicated all Sulf capable of productive hypoglycemia. Holikely to occur we deficient. The meal times for had been provided was at 7:45 A.M.	ew.omnicare.com/na/apps DrugImprint.aspx?impelD on drug information. ed the facility used the e as a drug reference for side effects, and for crushables and drug ed the licensed nurses d to use any ag reference of their own. Drug Information arsing, 2009, edition, mation on Amaryl Sulfonylurea, was arning information Conylurea drugs are cing severe typoglycemia was more hen caloric intake was for the Family Tree unit ed by the DoN. Breakfast ., and lunch at 12:15 P.m.					
	had been provide was at 7:45 A.M.	ed by the DoN. Breakfast					

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PREFIX	· ·	CY MUST BE PERCEDED BY FULL		REFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC1)		DATE
	3/10, Medication						
		Medication Pass Policy on					
	8/23/11.						
	Point #9 indicated medications were to be						
	in accordance with frequency prescribed						
	by the physician-	within 60 minutes before					
	or after prescribe	ed dosing time.					
	This federal tag relates to Complaint						
	IN00095160.	clates to Complaint					
	11100093100.						
	3.1-48(c)(2)						
	3.1- 4 6(c)(2)						
F0371	The facility must -						
SS=F		om sources approved or					
		ctory by Federal, State or					
	local authorities; a						
	under sanitary cor	, distribute and serve food					
	_	ation, record review, and	F03	₇₁	What corrective action(s) w	ill	09/22/2011
		cility failed to serve food	103	· •	be accomplished for those		55, 22 ,2011
		-			residents found to have been	<u>en</u>	
under sanitary conditions related to foods and beverages not covered with lids or plastic wrap when trays were transported				affected by the deficient			
					practice: No residents were		
		_			specifically identified as being	g	
	tnrough resident	care and public areas.			negatively affected by the		

000005

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETE	ED
		155005	B. WIN			08/23/201	1
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	MADISON AVE		
MANOR	CARE HEALTH SEF	RVICES		1	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re C	OMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	deficient practice. How other	\ <u></u>	DAIL
	_	ential to affect 162			residents having the potent		
		onsumed meals from the			to be affected by the same	<u></u>	
	· ·	out of a total population			deficient practice will be		
	of 162 residents.				identified and what correct	ve	
					actions will be taken; Resid		
	Findings include:				who consume meals from the	e	
					facility kitchen have the pote	ntial	
	The 8/23/11 me	al service to the front			to be affected by the same		
		s observed at 12:25 P.M.			deficient practice. Dietary ar		
					nursing staff will be educated the necessity to cover food a		
		taff members obtained			beverages during	iiiu	
	select meal orders from the 24 residents				transport. What measures v	vill	
		the kitchen, which was			be put into place or what		
	10 feet across a j	public entrance hall.			systemic changes will be m	ade	
	The meal service	e started after the select			to ensure that the same		
	menu orders wer	re received. Each of the			deficient practice does not		
	three staff memb	pers were observed to			recur: Food and beverages		
	carry a tray, do a	meal set-up, then return			transported through resident		
	1 .	The main entrees were			and public areas will be cove Education will be completed		
	1	d. None of the other food			dietary and nursing staff	WILLI	
		ges were covered.			regarding covering food and		
		•			beverages during transport.	How	
	Silverware was v	wrapped in a napkin.			the corrective action(s) will		
					monitored to ensure the		
	Dietary Aide #1,	who was assisting with			deficient practice will not		
	the front dining	room service from the			recur; i.e., what quality		
	kitchen, was inte	erviewed at 12:30 P.M.,			assurance program will be	<u>put</u>	
	8/23/11. Dietary	Aide #1 indicated the			into place;		
	1	not covered if sent in a			Food Service Manager or desig will monitor compliance weekly		
		ary Aide #1 indicated if a			using attached audit tool. Pleas		
		an open cart, the food			exhibit A. Observations will		
	I -	red with Saran. Dietary			continue for a minimum of six		
		d the food items on the			months. QA & A committee w	ill	
					review findings and determine	need	
	I -	ne front dining room were			for further monitoring and educ	ation	
		nuse it was just a few feet			per the QA & A process.		
	across the hall		1			I	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN OF CORRECTION		II 155005		A. BUILDING 00			COMPLETED	
				B. WING			08/23/2011	
_				STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.		
NAME OF I	PROVIDER OR SUPPLIER			1345 N	MADISON AVE			
	CARE HEALTH SEF				SON, IN46011			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DETRIENCT)		DATE	
	1	Resident (A), who was						
		m on the intermediate						
		ed at 12:35 P.M., 8/23/11.						
		observed over the juice						
	_	sident (A) indicated he						
	always ate in the room and usually only							
	the entree was co	overed.						
	The lunch meal p	The lunch meal pass to resident rooms on						
	the intermediate care unit was observed at							
	12:40 P.M., 8/23/11.							
	Eighteen lunch trays were observed in a							
	cart which had closed doors on each end.							
	The entrees were covered with a pod lid.							
		nilk, juice, coffee, or tea,						
	1	d. The fruit cups were not						
		can or other type of						
		• •						
	covering. The chocolate cake was not wrapped with Saran, nor covered in any way. Silverware was wrapped in a napkin.							
	1 -							
	CNA #1 was observed to move the cart from room to room, pass, and set up each							
	resident tray, before moving to the next.							
	CNA #2 was observed to carry trays the							
	length of the hall to resident rooms.							
		erviewed during the meal						
		-						
	_	indicated sometimes						
	Saran was placed over foods and beverages and sometimes not. CNA #1 indicated there had been 19 room trays on							
		•						
	the unit and the cart held only 18. CNA #1 indicated the room tray for Resident (A)							
	had arrived on an open cart, which held a							

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
		155005		B. WING			08/23/2011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ		
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	CARE HEALTH SEI	RVICES			SON, IN46011			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION	
TAG	ŧ	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
	1	and cups. CNA #1						
		ods and beverage of						
	` ′	d been covered with Saran						
	wrap because it	had arrived on the open						
	cart.	cart.						
	Day Cook #1, w	ho worked in the main						
	kitchen, was inte	rviewed at 1:00 P.M.,						
	8/23/11, and indicated if a tray was							
	served to the front dining room across the							
	hall, food items were not covered. Day							
	Cook #1 indicated if a tray went out on an							
	open tiered cart, food items were covered.							
	Day Cook #1 indicated oatmeal and soup							
	1 -							
	were exceptions, and were always covered							
	whether they went out on a cart or were served to a dining room. The room tray and dining room meal pass							
	to the back, Fam	nily Tree unit, was						
	observed at 1:05	P.M., 8/23/11. The room						
	trays were on a closed cart. The entrees							
	were covered, the beverages, fruit cups,							
	and chocolate cake, were not covered.							
	Silverware was wrapped in a napkin.							
		on an open tiered cart,						
	were covered wi	-						
		vrapped in a napkin.						
		were served from the hot						
	1							
	1 -	the Family Tree dining						
		s immediately adjacent,						
	were covered with pod lids, Saran wrap, and cup lids. Silverware was wrapped in a napkin.							

IDENTIFICATION NUMBER: 155005 NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES (N4) ID SUMMARY STATIMENT OF DEPICUNCIES PREFEX (EACH DEPICENCY MIST BE PERCEDDE BY FULL TAG Dictary Manager #1 was interviewed at 3.20 P.M., 8/23/11. Dictary Manager #1 indicated all food items were to be covered with poll ids, Saran, or cup lids, when transported. The Director of Nursing (DoN) provided the facility's 4/06, Tray Service and Transport Policy on 8/23/11. Point #6 of the guidelines indicated trays were transported in an enclosed cart whenever possible. Foods, beverages, and eating utensils were to be covered with lids, plastic wrap, or other suitable covering if Itarys were carried through patient care and public areas. Point #10 indicated tray transport carts were to be moved from room to room to minimize exposure to the air outside resident rooms. Point #10 indicated capping beverages might minimize applicance This federal tag relates to Complaint IN00095160. 3.1-21(i)(3)	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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